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First Report on the Prospective Payment Assessment Commission (ProPAC)

by the Office of Technology Assessment

Pursuant to Section 1886 (e)(G)(i) of the Social Security Act

March 25, 1985

Note: The Health Program Advisory Committee provided advice and comment to OTA on its oversight activities related to ProPAC generally and this report specifically, however, the content is the responsibility of OTA and does not constitute consensus or endorsement by the advisors. This is a special OTA report that has been neither reviewed nor approved by the Technology Assessment Board.

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Office of Technology Assessment
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BIBLIOGRAPHIC INFORMATION

PB85-184380

Report on the Prospective Payment Assessment Commission (ProPAC) (1st).

25 Mar 85

PERFORMER: Office of Technology Assessment, Washington, DC.

The Social Security Amendments of 1983 (P.L. 98-21) mandated the end of cost-based reimbursement under Medicare for inpatient hospital services and initiated a 3-year transition to a prospective payment system (PPS) based on diagnosis related groups (DRGs). The law also established an independent advisory commission called the Prospective Payment Assessment Commission (ProPAC). ProPAC's basic responsibility is to make recommendations to the Secretary of the Department of Health and Human Services (HHS) and the Congress on certain adjustments to the PPS, including the overall amount paid and the way prices are apportioned among the different DRGs. ProPAC is an independent agency within the Legislative Branch.

KEYWORDS: *Cost analysis, *Prospective reimbursement, *Medicare, *Hospital services.

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Introduction

The Social Security Amendments of 1983 (P.L. 98-21) mandated the end of cost-based reimbursement under Medicare for inpatient hospital services and initiated a 3-year transition to a prospective payment system (PPS) based on diagnosis related groups (DRGs). The law also established an independent advisory commission called the Prospective Payment Assessment Commission (ProPAC). ProPAC's basic responsibility is to make recommendations to the Secretary of the Department of Health and Human Services (HHS) and the Congress on certain adjustments to the PPS, including the overall amount paid and the way prices are apportioned among the different DRGs. ProPAC is an independent agency within the Legislative Branch.

The Office of Technology Assessment (OTA) was required to select and appoint the members of the Commission. OTA is also required to report at least annually to the Congress on the Commission's functioning and progress. This report is the first response to that mandate and covers ProPAC's first year of operations.

The report, issued before the first ProPAC report is delivered to the Secretary of HHS and the Congress on April 1, 1985, is primarily descriptive, focusing on ProPAC's operating processes and functioning. A discussion of the substance and content of the April 1985 ProPAC report and the responses stemming from it, will be the subject of an OTA report to be delivered to the Congress in the fall of 1985. That report will also cover ProPAC's comments on the Secretary's fiscal year 1986 PPS regulations.

Background on ProPAC's Creation

The passage of the Social Security Amendments of 1983 within four months of their introduction signaled an overwhelming agreement by Congress on the need to control the rising costs of Medicare. The PPS radically revised the incentives for the provision of hospital care. No longer would hospitals receive reimbursement for costs incurred. Instead, they would receive a fixed payment, set in advance, for each type of case and would be allowed to keep any surpluses but would have to absorb any excess costs.

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 and 10 years of prospective payment experiments and demonstrations had provided a conceptual foundation for enactment of PPS. But while the conceptual foundation had been laid, the technical issues needing resolution were extremely complex and numerous, ranging from problems with using DRGs as the case mix measure to problems with paying hospitals in different locations or paying for extremely expensive cases.

Congressional awareness of potential problems with the PPS was evident even as the law was drafted and is one of the explanations for provision of a 3-year transition to a national payment rate. In addition, some of the problems are explicitly addressed in the legislation by mandated studies. And in recognition of the need to change the overall level of PPS payment and the individual DRG weights and categories as medical practice changes, P.L. 98-21 established ProPAC to make recommendations on such changes. ProPAC was also designed to assist in explicitly addressing questions that were previously of lesser priority, such as what reasons are behind variation in medical practice across the country and which new technologies should be included in the system.

Thus, the PPS was intended to be evolutionary, with the overall goal of containing the increase in Medicare costs, while maintaining access to quality care for Medicare beneficiaries. And ProPAC was intended to play a role in its evolution.

ProPAC's Mandate

ProPAC's authorizing statute, the Social Security Amendments of 1983, established two specific responsibilities:

1) to recommend the updating factor (the percentage by which the overall system prices are increased annually), and

2) to make periodic recommendations concerning changes in individual DRG weights and categories, beginning with fiscal year 1986 and at least every 4 years thereafter. [See Appendix A for the statutory language.] The report containing these recommendations is due annually on April 1. In addition to these primary responsibilities, ProPAC is required to report to the Congress on any adjustments made by the Secretary of HHS to DRG classification and weights.

In order to make its recommendations, ProPAC was given the authority and responsibility to collect and assess information on the safety, efficacy, and cost-effectiveness of new and existing medical technologies.[1] It is also required to assess more general changes in the health care system affecting Medicare beneficiaries. The general areas of study include evaluating regional variations in medical practice and lengths of hospital stay, giving

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[1]OTA defines medical technology as the drugs, devices, and medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided.

special attention to treatment patterns for conditions that appear to involve excessively costly or inappropriate services not adding to the quality of care.

The statute provides that, where possible, ProPAC must use existing information, both published and unpublished. Congress clearly recognized the need to fill gaps in existing knowledge, though, in providing the authority for "original research and experimentation, including clinical research, where existing information is inadequate for the development of useful and valid guidelines by the Commission..."

The Deficit Reduction Act of 1984 (P.L. 98-369) gave ProPAC two additional specific tasks: 1) to study cardiac pacemakers and the relative weights assigned to those DRGs in which pacemakers are used, and 2) to make a recommendation regarding the overall annual rate of increase for non-PPS hospitals.[2] The results of the pacemaker study were due, and delivered, on March 1, 1985. The non-PPS recommendation is due along with ProPAC's PPS recommendation.

A final addition to ProPAC's duties is contained in the House of Representatives Report language for the 1985 Departments of Labor, HHS, Education, and Related Agencies Bill. This language, written in July of 1984, states, "the primary role of the Commission lies in a broader evaluation of

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[2]Hospitals exempt from PPS are: psychiatric hospitals, long-term care hospitals, children's hospitals, rehabilitation hospitals, distinct units of acute care hospitals for psychiatric or rehabilitative services, hospitals outside of the 50 States and the District of Columbia, and hospitals under state alternative payment systems exempted by waiver. There are also provisions for individual exceptions and/or adjustments for hospitals in another group of categories. Of all hospitals serving Medicare patients, 81% are under the PPS.

the impact of Public Law 98-21 on the American health care system." And, the House report directs ProPAC to submit an annual report to the Congress expressing its views on this broader impact of PPS, starting on October 1, 1985.[3] This date was later changed by the Chairman of the Subcommittee to February 1, 1986. While this report language does not have the force of law, ProPAC intends to comply.

Organization of the Report

The rest of this report is organized into four parts. The "Descriptive Overview of Status" contains information on the appointments and staffing of the Commission, the status of various administrative and operating activities, the organization of the Commission, and the substantive areas of concentration.

The next section, "Operating Strengths and Problems," provides an analysis of ProPAC's progress in key areas of operation. Next, "Issues for Future Consideration," contains questions that OTA and the Congress may wish to analyze in the coming year. Finally, "General Conclusions" presents OTA's overall views on ProPAC's first year.

There are six appendixes to this report. Appendix A contains copies of all statutory language on the Commission. Appendix B provides a glossary of selected terms used in this report and in general reference to ProPAC's tasks. Appendix C presents a list of ProPAC staff and their backgrounds. Appendix D lists the presentations that have been made before the full Commission and its Subcommittees. In Appendix E, the attendance of the Commissioners is shown.

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[3]Note that this report is in addition to ProPAC's annual April 1 reports.

Finally, Appendix F is a copy of ProPAC's materials describing procedures for interested parties to submit information to ProPAC with respect to medical and surgical procedures and services and problem areas in the DRG classification and weighting system.

Descriptive Overview of Status

Appointments and Staffing

The Director of OTA was required by the Social Security Amendments of 1983 to appoint the 15 members of ProPAC no later than April 1, 1984. OTA began the appointments process in July 1983, recognizing that if appointments could be made prior to April 1984, ProPAC would have extra time for its complex organizational tasks.

Nominations were solicited from a large number of professional, technical, public, labor and industry groups. Over 400 nominations were received. OTA appointed a special panel of outside experts to help review the qualifications of the nominees, and in October 1983, this panel met and provided its recommendations to the OTA Director. The Commission was appointed in November of 1983, effective December 1, 1983, four months ahead of schedule. It is important to note that the Commissioners were chosen as individuals and are not required to represent their nominating organizations.

Table 1 lists the members of the Commission and shows their professional positions and length of appointment. The term provided by law is three years, although shorter terms were initially possible so that no more than seven terms expire in any one year. Thus, there were three one-year appointments, six two-year appointments, and six three-year appointments. Because the appointments were made ahead of schedule, the first year of each

Table 1.--Commissioners

Commissioner	Term	Current Position
Stuart H. Altman (Chair)	3 years	Dean, Heller School, Brandeis University
Karl D. Bays	3 years	Chairman and Chief Executive Officer, American Hospital Supply Corporation
Harold A. Cohen	2 years	Executive Director, Health Services Cost Review Commission of the State of Maryland; lecturer, Department of Health Care Organization, The Johns Hopkins University
John W. Colloton	3 years	Director, University of Iowa Hospitals and Clinics; Assistant to the University President for Statewide Health Services
Yvette F. Francis	3 years	Medical Director, St. Albans Family Medical Center, N.Y.; Medical Director, Sickle Cell Center for Research
Sister Sheila Lyne	3 years	President, Mercy Hospital and Medical Center
Barbara J. McNeil	1 year	Professor of Radiology, Harvard Medical School, Brigham and Women's Hospital; Professor of Clinical Radiology, Harvard Medical School
Richard J. Mellman	3 years	recently retired as Vice President and Actuary, Prudential Insurance Co.
James J. Mongan	2 years	Executive Director, Truman Medical Center
John C. Nelson	2 years	practicing obstetrician and gynecologist
Ernest W. Saward	1 year	Professor of Social Medicine and Professor of Medicine, University of Rochester School of Medicine and Dentistry
Steven A. Schroeder	1 year	Chief, Division of General Internal Medicine, Department of Medicine, University of California at San Francisco; Member of the Institute for Health Policy Studies at UCSF
Bert Seidman	2 years	Director, Department of Occupational Safety, Health and Social Security of the AFL-CIO
M. Keith Weikel	2 years	President, Manor Health Care[a]
Irwin Wolkstein	2 years	principal officer in consulting firm, Health Policy Alternatives, Inc.

[a]Former Group Vice President, American Medical International, at the time of his appointment to ProPAC.

term was actually 16 months. In May of 1984, the OTA Director sent a letter to each Commission member specifying that his or her term expired on March 31st of 1985, 1986, or 1987 (or until a successor is named).

The bulk of the Commission Chairman's time during ProPAC's first two months of existence was spent soliciting suggestions and interviewing candidates for Executive Director. The Chairman, Dr. Stuart Altman, believed that the Executive Director should have, among other qualifications, a medical background to complement Dr. Altman's background in economics. The Commissioners unanimously approved the selection of Donald Young, M.D., at their February 1984 meeting.

Dr. Young assumed responsibility for hiring staff immediately upon his arrival. Appendix C presents a list of staff, showing their starting dates and subject areas in which they have experience. Of the 25 staff positions alloted by law, 8 were filled by the end of April 1984, 13 by the end of August 1984, 18 by the end of October 1984, and 21 are currently filled. In addition, there are several temporary employees (some have already completed their assignments), several in-house consultants, and two fellows.

Operating Activities

Perhaps the most difficult administrative issue in ProPAC's first year was the question of whether ProPAC was an independent Commission in the Legislative or the Executive Branch of government. The answer to this question had implications for numerous operating activities, including personnel policies, contracting policies, review of budgets by the Office of Management and Budget (OMB), appropriations review, and whether ProPAC is subject to the Freedom of Information Act. While OTA and Congressional

staffers interpreted the original statutory language as placing ProPAC with the Legislative Branch for operating purposes, some officials (primarily OMB) believed that ProPAC was part of the Executive Branch.

To clarify the intention that ProPAC's administrative home would be in the Legislative Branch, the Deficit Reduction Act of 1984, passed in July, contained language stating that, "[t]he Commission shall submit requests for appropriations in the same manner as the Office [OTA] submits requests for appropriations..." However, discussions between OMB and ProPAC over the summer showed that a discrepancy in interpretation remained. To assist ProPAC, OTA's general counsel reviewed the laws and delivered the opinion to OMB on September 18, 1984 that ProPAC should operate as a Legislative Branch agency. At present, this opinion has prevailed.[4]

Until the first staff were on board, OTA assisted ProPAC with its administrative operations. However, in early spring, a contract with the General Services Administration (GSA) was negotiated for various administrative support activities, including: payroll, travel arrangements and expenses, financial accounting, assistance with budget preparation, processing of purchase orders, moving, installation and maintenance of telephones, and printing. Interactions with GSA have been reported to be satisfactory. Although the Commission and staff were essentially operational by early summer 1984, it was not until November 1984 that the current office space in Southwest Washington, DC was occupied.

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[4]However, because the Chairmen of the Appropriations Committees have the opportunity to assign appropriations requests to the various Subcommittees, ProPAC will continue to submit its appropriations requests to the Subcommittee on Labor, Health and Human Services, and Education of the House Committee on Appropriations and to the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies of the Senate Committee on Appropriations.

In fiscal year 1984, ProPAC had $1.5 million available. Due partially to the pace and timing of staff arrivals and partially to conservation because of uncertainty over fiscal year 1985 appropriations, only a third of the funds were spent. For fiscal year 1985, ProPAC received its full budget request of $3.4 million, comprising $2,424,000 in new budget authority and $1,054,000 in carryover from fiscal year 1984. Table 2 shows fiscal year 1984 expenditures along with the approved fiscal year 1985 budget and first quarter expenditures. With the exception of the $1.0 million research budget, expenditures seem on target with budgeted amounts. If research funds are expended, as is expected, it appears that continuation of current spending plans and rates will require $3,131,000 of the original $3,478,000. This prediction is based on estimates of continuing expenditure increases by quarter and will become firmer as data for quarters beyond the first become available. Both the amount of the total budget and the way in which it is categorized appear appropriate for the designated functions.

Organization of the Commission

Following its third meeting, the Commission was divided into three subcommittees. Table 3 shows the membership of each subcommittee along with a listing of their meeting dates. Every Commission member is a member of either the Subcommittee on Diagnostic and Therapeutic Practices or the Subcommittee on Hospital Productivity and Cost-Effectiveness. The third subcommittee, on Data Development and Research, is composed of members from each of the other two. The Chairman is not an official member of any subcommittee, but frequently participates in meetings of all three. The subcommittee structure was designed to provide a more manageable working organization, divided

Table 2.--ProPAC Budget for Fiscal Years 1984 and 1985
(dollars in thousands)

OBJECT CLASSIFICATION:	FY 1985 APPROVED* BUDGET	FY 1985 1ST QTR. ACTUAL OBLIGATIONS	FY 1984 ACTUAL OBLIGATIONS
Salaries:**			
Full-time staff	$1,072	$221	$225
Other than full-time	179	25	43
	$1,251	$246	$268
Benefits:	$150	$ 29	$30
Travel:	$ 80	$ 45	$49
Transportation of things:	$ 0	$ 0	$ 1
Standard level user charges:	$ 87	$ 22	$ 0
Communications, utilities, and other rent:			
Mainframe Computer services	$150	$--	$--
Xerox	25	--	4
Telephone	80	--	2
Postage	25	--	1
	$280	$14	$ 7
Printing and reproduction:	$ 75	$1	$2
Other services:			
Research data and policy analysis studies	$1,000	$--	$--
Other contracts	--	--	12
GSA services	50	--	27
	$1,050	$54	$ 39
Supplies and materials:			
Supplies	$20	$--	$2
Publications	6	--	1
	$26	$3	$3
Equipment:			
Personal Computers	$100	$--	$--
Office	32	--	--
	$132	$55	$ 47
TOTAL OBLIGATIONS	$3,131	$469	$446
CASH OUTLAYS:			
from current year	$2,831	$250	$330
from prior year	116	--	NA
TOTAL OUTLAYS	$2,947	$250	$330

NA indicates not applicable

*This budget is a slight decrease from the approved budget. For FY 1985 there was $2,424,000 approved in budget authority with $1,054,000 in carryover from FY 1984, making a total of $3,478,000. ProPAC expects to have $347,000 for carryover to FY 1986.

**Note: Commissioners receive a daily rate of $278.08 for their time plus standard government travel reimbursement.

Table 3.--ProPAC Subcommittee Memberships

Subcommittee on Diagnostic and Therapeutic Practices:

Barbara J. McNeil, Chair
Karl D. Bays
John W. Colloton
John Clark Nelson
Ernest W. Saward
Steven A. Schroeder
Irwin Wolkstein

met: July 4-5, 1984; Sept. 9-10, 1984; Oct. 9-10, 1984; Dec. 12-13, 1984; Feb. 12, 1985; Mar. 5, 1985

Subcommittee on Hospital Productivity and Cost-Effectiveness:

Harold A. Cohen, Chair
Yvette F. Francis
Sister Sheila Lyne
Richard J. Mellman
James J. Mongan
Bert Seidman
M. Keith Weikel

met: July 9-10, 1984; Aug. 9-10, 1984; Sept. 11, 1984; Oct. 15-16, 1984; Dec. 10-11, 1984; Jan. 15, 1985; Feb. 12, 1985; Mar. 5, 1985

Subcommittee on Data Development and Research:

Steven A. Schroeder, Chair
Harold A. Cohen
Yvette F. Francis
Barbara J. McNeil
Richard J. Mellman
Irwin Wolkstein

met: Nov. 7, 1984; Jan. 16, 1985; Feb. 13, 1985; Mar. 6, 1985

roughly along the lines of ProPAC's two primary responsibilities, with research supporting both.

In general, the Diagnostic and Therapeutic Practices Subcommittee is responsible for assessing individual technologies and making the DRG recalibration recommendations, while the Hospital Productivity and Cost-Effectiveness Subcommittee is responsible for making the annual update factor recommendations. The Subcommittee on Data Development and Research has assumed responsibility for organizing the outside research agenda and selecting contractors. Although formed along with the other subcommittees, the Data Development and Research Subcommittee did not meet until November 1984, to give the other subcommittees time to begin their work and assess their data and research needs.

In the early months of the subcommittees' existence, a number of Commission members expressed concern regarding coordination of decisions made by each subcommittee. The possibility was thoroughly discussed that two independent sets of decisions could "cancel" each other with respect to some overall budgetary goal for the Medicare program set by the Commission. One proposal was that one subcommittee could make its recommendations first, with the other one assuring that its recommendations did not conflict with the first set. While the careful consideration of this process demonstrated good foresight and responsibility on the part of the Commission, to date, the recommendations of the two subcommittees have not been at odds. Furthermore, the fact that the subcommittees make their recommendations to the full Commission for final approval has assisted in the successful functioning of the organizational structure.

Substantive Areas of Concentration

The early months of the Commission's operation were spent getting organized, developing a policy statement and rules of procedure, and learning about the workings of the PPS. There were several detailed presentations by the Health Care Financing Administration (HCFA) to assist Commission members in understanding the details of the system. Another important part of the early months was spent getting to know the "constituents" of the Commission--the groups that would provide information and would be those directly affected by the Commission's recommendations. A list of presentations made before the Commission can be found in Appendix D. In recent months, presentations have been generally limited to subcommittees and Commission staff.

This description and discussion of substantive areas of concentration is organized according to which Subcommittee has considered the area. It is important to note, however, that both the mandates of the Subcommittees and the subjects they cover overlap to some degree. Furthermore, all decisions on recommendations are made by the full Commission.

Diagnostic and Therapeutic Practices Subcommittee. This Subcommittee spent its early meetings establishing a two-stage process to select issues for potential DRG category or weight adjustments. The detailed process was approved by the full Commission in September 1984. Currently, the Subcommittee plans to reevaluate the process at its first meeting subsequent to the April 1985 report.

The first step in the process is an initial Screening Analysis prepared by the staff. Then, after screening guidelines are applied, a technology or issue is selected for an Indepth Analysis.[5] Issues for screening come to ProPAC's attention from external sources (such as medical specialty societies, the hospital industry, or Congress) and from internal staff or Commissioner analyses. The initial Screening Analyses summarize existing information on the safety and efficacy of the technology or practice patterns under consideration, the populations affected, costs and quality, availability of data, and current DRG classification and weight. The screening guidelines for selecting technologies for Indepth Analysis focus primarily on the interaction between quality of care and potential short-term or long-term Medicare payment problems.

Table 4 lists the specific technologies and diagnoses considered by the Subcommittee. Indepth Analyses have been completed for cardiac pacemaker implantation, cataract extraction and intraocular lens (IOL) implantation, and percutaneous transluminal coronary angioplasty (PTCA)[6] for recommendations in ProPAC's April 1985 report. Indepth Analyses are usually illustrative of a particular type of problem that might be applicable to other technologies or problem areas not specifically studied by the Commission. The Indepth Analysis of IOLs demonstrates this principle.

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[5]"Indepth Analysis" is the phrase used by ProPAC for its detailed studies of particular technologies, diagnoses, or DRGs.

[6]PTCA is a relatively new method of treating localized coronary artery stenosis and relieving symptoms of angina pectoris. It is considered to be an alternative to drug therapy and to coronary artery bypass surgery. As an alternative to surgery, it is possibly a cost-reducing technology.

Table 4.--Technologies and Diagnoses Considered by the Subcommittee on Diagnostic and Therapeutic Practices

Indepth Analysis for April report:

1) Cataract extraction and intraocular lens implantation
2) Percutaneous transluminal coronary angioplasty (PTCA)
3) Cardiac pacemakers

Indepth Analysis in progress (no recommendations in April report):

1) Cyclosporine
2) Magnetic Resonance Imaging
3) Bilateral Hip Replacement (Dual Joint Procedures)
4) Alcohol Dependence
5) Skin Disorders
6) Cystic Fibrosis
7) Extracorporeal shock wave lithotripsy
8) Cochlear implantation

Considered, but no Indepth Analysis planned at present (a decision for no recommendation was made):

1) Bone-marrow transplantation
2) Infective Endocarditis

IOL implantation represents a dramatic change in medical practice between 1981, the year used to establish the DRG weights, and the present time. In 1981, only about 20% of cataract extractions were followed by IOL implantation, but in 1984, the figure reached approximately 80%. Under PPS, the payment for the extraction falls under DRG 39, with or without IOL implantation. Because IOL implantation uses more resources than would be accounted for in the 1981 average cost per case, ProPAC's analysis had to first examine the changes in resource consumption. The analysis then had to identify the implications for either allowing general recalibration to correct the PPS price-versus-cost discrepancy or for specifically modifying the weight for DRG 39 to account for changes that would not be reflected in a general recalibration. This situation is one that is certain to arise for many future changes in medical practice.

In addition to studying specific technologies and issues related to specific DRG categories and weights, the Subcommittee has examined and is continuing work in a number of areas. One such area is the allocation of nursing costs and the DRG system. The basic issue under consideration is whether the use of allocated per diem nursing costs in constructing the DRG weights adequately measures a hospital's resource use in each DRG. Because it is generally accepted that the method used to account for nursing costs probably contributes to compression of DRG weights,[7] this area has been slated for future consideration. A ProPAC staff paper has been prepared that provides an overview of this area.

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[7]Compression of DRG weights is the underestimation of resource costs of relatively complex (and expensive) cases and the overestimation of resource costs of relatively simple (and inexpensive) cases.

The Subcommittee requested that ProPAC staff prepare an overview paper (for its December 1984 meeting) and is continuing work in the area of general DRG classification and construction issues. Specific topics for analysis include, among others: the use of the primary versus the principle diagnosis for DRG assignment; the age split for certain DRGs; the appropriateness of using secondary diagnoses for DRG classification for Medicare beneficiaries; which secondary diagnoses are appropriate for use in classification; how to incorporate updates to the procedure code system (the ICD-9-CM); the adequacy of the data bases used to construct and classify DRGs; and problems with the software that assigns patients to DRGs.

Measuring the quality of care, particularly with respect to health outcomes has received emphasis from the Subcommittee. One of the first staff assignments was to prepare a paper on the topic. In addition, the Subcommittee had several presentations on the state of the art of quality assurance. Both the Subcommittee and the full Commission have committed to further work in this area. How to ensure that the Commission's decisions have no adverse effects on the quality of care has been a frequent topic of discussion.

Finally, the Subcommittee has discussed the adoption of new technologies on numerous occasions. This area is slated for future study.

Hospital Productivity and Cost-Effectiveness Subcommittee. This Subcommittee spent its first meeting elaborating its charge. At that time, the responsibility for recommending the annual update factor was divided into two main areas--the increase in inflation in the hospital sector (referred to as the hospital market basket of goods and services, or the market basket recommendations, for short) and the increase for other factors (referred to as

the Discretionary Adjustment Factor, or DAF). The early meetings were also used to gather information about how the rate-setting states updated their systems. One of the early assignments was a staff paper on measuring change in the hospital product. This area was identified as needing future study.

The Subcommittee devoted substantial effort in developing its recommendations on the hospital market basket. There were presentations in August and September, a tentative set of recommendations in October, a modified set in December, and unanimous approval by the full Commission in January. The specific issues covered in the recommendations that will appear in the April report concern: the number of market baskets by region and classes of hospitals within regions; the use of different market baskets for hospitals exempt from PPS; how to treat the wage component of the market basket and what measures to use; whether the update factor should include a correction for substantial errors made in the previous year's forecast of changes in the market basket; what constitutes a substantial error; and whether the market basket weights should be rebased and how often.

The discretionary adjustment factor (DAF) received an equal amount of effort, although the analysis was not started until the market basket work was well under way. The DAF recommendations will stem from a two-step process: first, a set of principles was developed and adopted (during the December and January meetings), and second, a numerical value for DAF will be set. Considerations included in the principles were: should a change in productivity[8] be included in the DAF, if so, how can a high level of

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[8]Productivity has been defined as more outputs or units of product for the same amount of inputs or resources, or the same outputs with fewer inputs.

productivity be encouraged while maintaining high quality care and long-term cost-effectiveness of the system; should the DAF provide for technological change, if so, how can the DAF be used to finance development and diffusion of new scientific and technological advances; should DAF reflect changes in case mix, and if so, how can real changes in case mix be distinguished from changes in coding error. Following the development of principles, the Subcommittee analyzed whether to recommend a single value for the DAF or a range of values, whether to blend the components of DAF (e.g., productivity or technological change) into a single value or to recommend a number for each component, and whether to recommend the same amount for the DAF for the hospitals exempt from PPS.

Another topic that received a great deal of consideration by the Subcommittee was disproportionate share hospitals, or public or other hospitals that serve a significantly disproportionate number of patients who have low income or are Medicare part A beneficiaries. The Subcommittee's activities (discussions in September, presentations in October and December, recommendations developed and modified in December, January, and February) in this area arose due to the concern that higher costs in these hospitals might lead to lower the quality of their care in the absence of a specific adjustment to their PPS rates. Issues analyzed for current recommendations and future study include: how to precisely define disproportionate share hospitals; whether Medicare part A beneficiaries should be included in the definition; and whether a method should be developed to adjust PPS rates for disproportionate share hospitals, and if so, for what year.

Because approximately 79% of each hospital's payment rate is adjusted by the area wage index, the Subcommittee examined the composition of hospital labor market areas and the area wage index. Issues considered in developing a recommendation for the April report were: are there significant differences in wages in the inner city compared with suburban areas within the same metropolitan statistical area (MSA); are there significant variations in different rural locations within a state; how can hospital labor market area be best defined; and if a change is made in the area wage index, should an adjustment be made for any increases or decreases to aggregate payments.

The issue of recommending a change in the transition from a blended Federal/hospital-specific payment rate to a national rate was considered by this Subcommittee in its January and February meetings, although the treatment of the issue in the April report was an issue for the full Commission. Discussions about the transition focused on potentially slowing the transition only if the concerns raised in the Commission's other recommendations were not addressed by the Secretary of HHS. In its March meeting, the full Commission reviewed some new data that had become available. The staff was directed to prepare an analysis, using the new data, of the implications for continuing with the transition or slowing its timetable. Current plans are that the Commission will conduct an additional analysis on the transition and may deliver an additional report to the Secretary in June 1985.

Other Areas of Concentration (considered by the full Commission). In addition to those topics considered in depth by the two main Subcommittees, the Commission considered several areas in its more recent meetings. The first group of topics was discussed at as detailed a level as possible for the

first year, with the goal of including recommendations in the first April report. The second group of topics was discussed only briefly at this time, with further study recommended. All of these topics are expected to be the subject of more complete analyses in ProPAC's second year.

The first group of topics[9] includes rebasing the standardized amounts, recalibration/reweighting of the DRGs,[10] and normalization of the DRG weights. Issues considered related to rebasing include: when more recent cost data will be available; when the first rebasing should occur; what the frequency and timing of future rebasings should be; and what the method or process of rebasing should be. Issues considered related to recalibration/reweighting include: should recalibration be used to correct partially for DRG weight compression; should recalibration be based on the most recent charge data available (the 1984 PATBILL file), on the most recent cost data available (1982) applied to 1984 charges, or on combined PPS charges and costs (possible in 1987 for fiscal year 1988 rates). Whether to normalize DRG weights involved a decision about maintaining budget neutrality, in the face of aggregate increases brought about by recalibration or reweighting.

The second group of topics deals with the adequacy of various data bases for setting standardized amounts, including specific issues: how reliable the charge and cost data are, when they are available, and how to combine them. Other areas for future analysis include an examination of

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[9]These topics are highly technical and are described briefly in the glossary. OTA refers the reader of this report to the forthcoming April report by ProPAC for more information.

[10]As noted in the glossary of selected terms, recalibration refers to adjusting all DRG weights, while reweighting refers to adjusting certain DRG weights.

methods to modify payment amounts, including recalibrating, reweighting, and specific pricing; and methods to determine the DRG weights, including a study of per diem nursing costs, ancillary costs, and other costs as well as pricing. Finally, the topic of regional variations in medical practices has been noted as one of importance for future work, although no analysis has yet been undertaken.

Data Development and Research Subcommittee. The first meeting of this Subcommittee was in November of 1984, where a draft research budget was developed and adopted in principle. This budget divided the million dollars into six general areas (sic): computer support services contract, research support services contract, practice patterns variation grant, major research contract, data acquisition, and sole-source contract. In its second meeting, the Subcommittee developed a list of possible research topics and asked the rest of the Commissioners to set priorities. During the third meeting, the list of topics presented in Table 5 was developed (the table is not necessarily in priority order).

To date, the only contract underway is for computer support. The contract is for $40,000, although ProPAC expects to spend $100,000 for programming and analysis of Medicare data for recalibration and in-depth studies of DRG issues, etc. Although the other contracts are not final, ProPAC staff are in the active process of developing a task order contract with a major research group in order to obtain a variety of shorter term analyses and working with HHS to obtain proposals to study variations in medical practices. During the March meeting, the Subcommittee noted its intention to devote resources to research on allocating nursing costs to DRGs.

Table 5.--ProPAC Candidate Extramural Research Topics

Detecting changes in quality of care and health outcomes.

Distinguishing between true case mix change and coding change.

Changes in the hospital product, including "unbundling" of the inpat nt hospital stay.

Effect of PPS on hospital adoption of new technologies.

Synthesis of data and anecdotal evidence on the effects of PPS on th health care system.

Study of nursing "intensity" and allocation of nursing costs.

In-depth analysis of DRG weight and classification issues (referred the Subcommittee on Diagnostic and Therapeutic Practices).

Development of improved hospital market area definitions for applica on of the hospital wage index.

Analysis of the relationship between patient income and Medicare cos per case, for application to the disproportionate share hospital issue.

Cross-subsidization in hospital cost and charge allocation procedure

Evaluation of alternative patient classification systems and their p ential to improve measurement of severity.

Determination of causes of geographic variation in medical practice tterns affecting Medicare expenditures and hospital utilization.

Long-term effects of different update amounts.

Analysis of issues concerning the construction of the hospital marke basket.

Assessing the impact of changes in outlier payment policy.

The effects of PPS on minorities.

The effects of PPS on disease prevention technologies.

Analogous to the way HIPI was developed some years ago to refine the PI (i.e., separate measures of price, volume, and intensity increase co onents), develop a measure of increase in revenues for hospital type of servi which separates price, volume, true intensity, coding creep, cost shifting unbundling, etc.

Because the major research activities are not yet underway, it is impossible to comment on them. However, the Subcommittee (endorsed by the full Commission) has effectively adopted some policies that are worthy of mention. One is that the research projects to be undertaken should be timely enough to assist ProPAC in its decisions on DRG recalibration and reweighting and on the overall system update factor and its report on the effects of PPS on the health care system. As can be seen from Table 5, most topics support both duties. Another policy is that ProPAC will make every effort to utilize existing data and to monitor Federal and private sector PPS research to avoid duplication of effort. Finally, the Subcommittee has noted that research on higher priority topics might have to be forgone if no researchers are available. It has thus directed staff to be aware of opportunities for research in all areas identified.

Operating Strengths and Problems

This section of the report provides an overview of ProPAC's strengths and problems in its first year of operation. The order of the areas covered does not have particular significance. Rather, this section is meant to convey the sense that ProPAC has done many things well, has encountered some difficulties, and has either resolved them or has recognized them and is in the process of attempting to resolve them.

The participation and attendance of the Commissioners has been outstanding. Appendix E shows the attendance of the Commissioners at Subcommittee and full Commission meetings. The statistics are striking: 11 Commissioners had perfect attendance at full Commission meetings, and most Commissioners with less than perfect attendance at full Commission meetings

had perfect attendance at the Subcommittee meetings. Perhaps even more important, the Commissioners were readily available to the ProPAC staff by telephone and in many cases, individual meetings. Many Commissioners collected information on their own initiative or with the assistance of outside groups that contacted them. Particular mention should be made of the extraordinary amount of effort on the part of the Commission Chairman. Clearly, the Commissioners took the time commitment that was stressed at the time of appointments quite seriously.

The quality and backgrounds of the ProPAC staff appear to result in an effective blend of skills. Appendix C shows that staff members have expertise in medicine, health services research, medical records, nursing, hospital financial management, medical technology assessment, economics, public policy, law, and data analysis, among others. Most individuals bring more than one area of expertise. The staff has produced many informal products (staff papers) of high quality. It would be helpful if ProPAC could appoint, on a temporary basis, bachelor's level research assistants who would not be counted in the statutory ceiling of 25 staff.

An important operating strength is best described as how the Commission functions. As noted earlier, the Commissioners bring very different perspectives, points of view and types of knowledge to the Commission. It was not surprising, then, that there was often sharply contrasting opinions at the Subcommittee and full Commission levels. The Chairs of each of these groups, particularly Dr. Altman, have done an excellent job.

ProPAC's relationship with HCFA appears to be excellent, despite some early concern that the relationship might be a difficult one. On both formal and informal levels, HCFA has provided all of the information requested by the Commission or the staff. HCFA officials have briefed the Commission numerous times. In addition, data available to HCFA have been made available to ProPAC staff. The lines of communication apparently remain open in both directions. For example, ProPAC's Chairman and Executive Director met with HCFA's Administrator on February 27, 1985 to brief her on ProPAC's expected recommendations. The purpose of the meeting was to assist HCFA in getting a head start on its report on the recommendations due on June 1, 1985.

The importance of effective working relations between ProPAC and HCFA can not be overemphasized. ProPAC clearly needs assistance and cooperation from HCFA, and HCFA should benefit from ProPAC analyses. Yet it is still too early to determine the most appropriate form of ProPAC/HCFA interactions: will Medicare benefit more from "a cordial working relationship" or from "a relationship involving some creative tension"?

ProPAC's relationship with OTA is also excellent. OTA's staff person responsible for ProPAC liaison attends all meetings of the Commission and Subcommittees, including the executive sessions. All materials are provided to OTA at the same time they are provided to the Commissioners. Periodic meetings on the status of operations or work underway have been held throughout the year. Although OTA provided administrative assistance to the Commission before staff were hired, the relationship since that time has been one of observation and interaction among colleagues, rather than one of giving direction or participation in the workings of the Commission.

In general, ProPAC's relationships with outside groups have been very good. As evidenced by Appendix D, ProPAC spent a great deal of time establishing working relationships with a number of outside groups, including the Congressional agencies (OTA, CRS, CBO, and GAO), HCFA, and the American Medical Association (AMA), the American Hospital Association (AHA), the Health Insurance Agency of America (HIAA), the Health Industry Manufacturers Association (HIMA), several unions, some individual manufacturers, and numerous others. All of those organizations have offered and appeared to follow through on providing information.

The analysis on pacemakers provides a good example of ProPAC's interactions with outside groups. When the study on pacemakers began, HIMA offered to share its information on pacemaker costs and to coordinate obtaining new information from some member manufacturers. ProPAC staff had many data gathering conversations with HIMA and with the manufacturers. Because of the tight deadlines by which the data had to be analyzed and presented to the Commission for decision making, several manufacturers, having come to different conclusions, expressed concern that their numbers were not used in ProPAC's analysis. The manufacturers had not seen the method of analysis before it was presented to the Commission, and they believed that another method was more appropriate. It was their belief that the Commissioners should have been made fully aware of the methodological difference before making a recommendation.

These problems were identified and corrected within several days of their origin. ProPAC, HIMA staff, and the manufacturers met and discussed their methodological differences. The Commissioners each received a letter from HIMA which discussed HIMA's concerns. And the report was revised to

include some alternative methods of analysis. The Commissioners did not change their recommendations. Yet it is important to note that problems arose and were addressed: the outside groups' concerns with the process received a response. It is critical that ProPAC remain sensitive to potential problems such as this one.

Getting and using data have been both a source of achievement and a problem. At this time, ProPAC has most of the data that are available, including the 1981 MEDPAR file, 1981 cost reports, and the 1984 PATBILL file. Because there are no cost reports available for any PPS year, and because the PATBILL file is skewed towards early reporting hospitals and hospitals earning a surplus, the available data are quite limited. Nonetheless, this information is the same as HCFA has for its calculations. Another drawback, however, is that the tapes were not available until December of 1984 and January of 1985, and they were not in working format even then. ProPAC is presently working with a computer programmer to improve its ability to use data more readily, however, and the problem of the time it takes to develop the software for data analysis and clean the tapes should not be present in the future.

The decision to purchase personal computers has proven to be a good one. The computers are in constant use, both for data analysis and word processing. It seems clear that the amount of material produced in the amount of time it was would not have been possible without this investment in productivity.

Another issue is ProPAC's public process in general. Although not required by law, ProPAC has adopted the policy of operating in open meetings to the greatest extent possible. Almost all meetings in the first year, and most in recent months, have been open to the public. Requests by ProPAC for information from the public were made orally for some time. On January 11, 1985, ProPAC published a procedure for submission of information with respect to medical and surgical procedures and services in the Federal Register. A copy of this notice is found in Appendix F. Throughout the year, there was a surprising scarcity of public correspondence, although it increased towards the end of 1984.

From the start, ProPAC received complaints about the lack of public access to information about its operations and analyses, allegedly making external groups' participation in the meetings nearly impossible and observation less meaningful. ProPAC responded by providing handouts on decision items at meetings, assuring that there were enough chairs, using microphones, and allowing for public comments as part of every agenda. Furthermore, draft minutes from Subcommittee or Commission meetings were made public prior to official approval. A mailing list was developed for distribution of the minutes and other material.

Despite these efforts, there has still been some dissatisfaction on the part of the public, notably over the pacemaker study. Some problems will be logistically difficult to resolve. However, although public distribution of staff papers prior to their review by the Commission is clearly not desirable, ProPAC should try to build enough time into its decision processes in order to allow public comment on documents before they become final. It is ProPAC's intention to assess its public process as soon as the April report has been

completed. In that review, it would be useful for ProPAC to develop explicit, public criteria for making decisions about whether to screen particular technologies and issues.

ProPAC's growth in staff size was somewhat slower than had been hoped. Only a small core of staff was hired by April, and the majority did not arrive until the summer. As this was an entirely new agency, the learning time necessary for any new staff was formidable, and this unfortunately detracted from time that might have been spent on analyses for the April report. The difficulty of starting the operation of a new organization and interviewing potential staff simultaneously should not be ignored, however. Additional reasons for the rate of staff growth were uncertainties over fiscal year 1985 appropriations and uncertainties over what additional skills would be complementary to those on board. The end result, though, is a strong staff, and the problem is only a transient one.

Finally, the fact that ProPAC has not begun its outside research is an item significant to note at this time, but not necessarily one of serious concern if research contracts are rapidly let. In July of 1984, OTA expressed concern to ProPAC that it had no contracting expertise on site to be able to award contracts. An attorney with such experience was hired in December. The Data Development and Research Subcommittee did not meet until November of 1984, at which time the research agenda development was started. Clearly, because of the normal learning time for the Commission and its staff, the research needs were unknown early on. There is every indication that ProPAC will indeed award all of the fiscal year 1985 research monies, although the actual products will not be ready until sometime in fiscal year 1986.

Issues For Future Consideration

There are several issues that the Congress may wish to consider and OTA may therefore wish to discuss in future evaluations of ProPAC's functioning and progress:

- How broad or narrow should ProPAC's mandate be?

As set forth in the Social Security Amendments of 1983, ProPAC's mandate can be interpreted rather narrowly as making recommendations in two specific areas of the PPS--the amount of the overall updating factor and changes in DRG classification and weights. Several organizations and some members of Congress believe that ProPAC's efforts should be limited to those two areas. Others, however, interpret ProPAC's authority to assess medical practices and the quality of care as giving ProPAC broad authority in evaluating the PPS and recommending changes that will impact on or interact with the two specific areas. The House Appropriations report language concerned with the fiscal year 1985 appropriations lends support to the broader interpretation. There does not appear to be a uniform Congressional consensus with respect to this issue.

A corollary issue concerns the amount of ProPAC's research budget that should be spent evaluating the impact of PPS on the general health care system (as requested by the House Appropriations Committee). Because much research will serve both functions, this issue may not be as sharply drawn as is sometimes supposed.

- Is ProPAC asking the right questions?

At this point in time, the answer seems to be "yes", although the scope could be questioned by some. This issue will need more thorough evaluation in the future.[11] One important area, among others, that needs exploration is the amount and type of attention paid during ProPAC's deliberations to measuring and maintaining quality care.

- What is the perceived goal of ProPAC, and how effectively is ProPAC organized to achieve that goal?

There are a variety of perceptions that exist about ProPAC's goal. The Commission Chair has been quoted as stating that ProPAC has a role as an "honest broker," or an independent, unbiased Commission to make the system work more effectively. Some observers believe ProPAC's goal is to assure that quality enhancing, but cost increasing, technologies can enter the medical care system; others believe ProPAC should focus on encouraging the adoption of cost-effective technologies while still maintaining the overall cost containment goals of PPS. Still other observers see ProPAC as a source of needed technology assessment and research on medical practice patterns, while yet others feel strongly that ProPAC's role in these areas must be strictly confined to research that directly supports ProPAC's two original responsibilities. One important role of ProPAC, even in a year of budget freezes, is that it can provide good analytical information to assist the Congress in choosing between alternatives that all contain some cuts to the health care system.

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[11] And will be covered in OTA's fall 1985 report on the functioning of the Commission.

A related set of issues is whether ProPAC is appropriately located as a Legislative Branch agency, whether its relationship with HCFA is constructive, and whether its internal organizational structure leads to the best decisions. It is too early to identify problems in these areas at this time, but they might need examination in the future.

- Should ProPAC put more effort into assessing specific technologies?

Currently, ProPAC is looking at several specific technologies but in the context of also examining structural issues in the DRG system. This strategy appears reasonable for the present time, particularly given the different views in the Congress regarding ProPAC's mandate, but the question should be reexamined at a later date. In evaluating this issue, the degree to which information on technologies is currently lacking needs attention.

General Conclusions

OTA concludes that in its first year of operation, ProPAC's overall performance has been of a high order, and in some respects exceptionally high. For the most part, ProPAC's startup has been orderly and rapid and its work has been respectable in quantity and quality for an organization of its size and age. With attention to a few problems and with a year of experience, it can be anticipated that ProPAC's second annual report will cover a greater number of substantive areas and have greater analytical depth. OTA believes that ProPAC's resources are adequate and necessary for its job.

As in any new organization, the Commission and staff necessarily spent a certain amount of time in assessing their charge, in learning about the subject under study (the PPS), in learning how to work as an organization, in

developing methods of approaching their responsibilities, and in setting priorities. All of these tasks were approached in a timely fashion.

Although its responsibilities were great, it appears that ProPAC will meet its first year deadlines. In the case of the report due on April 1, 1985, timeliness is essential in order for ProPAC's recommendations to affect the PPS regulations for fiscal year 1986. The Commission and the staff worked diligently to accomplish this goal. In the case of the pacemaker report, delivered to Congress on March 1, 1985, there is a question as to whether the desire to meet the deadline, necessitating the forgoing of additional information, was appropriate. However, it is quite unlikely that further time would have substantially changed the report's recommendations.

Appendix A

Relevant Statutes

Establishment of the Prospective

Payment Assessment Commission

(2) The Director of the Congressional Office of Technology Assessment (hereinafter in this subsection referred to as the "Director" and the "Office", respectively) shall provide for appointment of a Prospective Payment Assessment Commission (hereinafter in this subsection referred to as the "Commission"), to be composed of independent experts appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service). In addition to carrying out its functions under subsection (d)(4)(D), the Commission shall review the applicable percentage increase factor described in subsection (b)(3)(B) and make recommendations to the Secretary on the appropriate percentage change which should be effected for hospital inpatient discharges under subsections (b) and (d) for fiscal years beginning with fiscal year 1986. In making its recommendations, the Commission shall take into account changes in the hospital market-basket described in subsection (b)(3)(B), hospital productivity, technological and scientific advances, the quality of health care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care), and long-term cost-effectiveness in the provision of inpatient hospital services.

(3) The Commission, not later than the April 1 before the beginning of each fiscal year (beginning with fiscal year 1986), shall report its recommendations to the Secretary on an appropriate change factor which should be used (instead of the applicable percentage increase described in subsection (b)(3)(B)) for inpatient hospital services for discharges in that fiscal year.

(4) Taking into consideration the recommendations of the Commission, the Secretary shall determine for each fiscal year (beginning with fiscal year 1986) the percentage change which will apply for purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B)) for discharges in that fiscal year, and which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

(5) The Secretary shall cause to have published in the Federal Register, not later than—

(A) the June 1 before each fiscal year (beginning with fiscal year 1986), the Secretary's proposed determination under paragraph (4) for that fiscal year for public comment, and

(B) the September 1 before such fiscal year after such consideration of public comment on the proposal as is feasible in the time available, the Secretary's final determination under such paragraph for that year.

The Secretary shall include in the publication referred to in subparagraph (A) for a fiscal year the report of the Commission's recommendations submitted under paragraph (3) for that fiscal year.

(6)(A) The Commission shall consist of 15 individuals. Members of the Commission shall first be appointed no later than April 1, 1984, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than seven members expire in any one year.

(B) The membership of the Commission shall provide expertise and experience in the provision and financing of health care, including physicians and registered professional nurses, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and individuals having expertise in the research and development of technological and scientific advances in health care. The Director shall seek nominations from a wide range of groups, including—

(i) national organizations representing physicians, including medical specialty organizations and registered professional nurses and other skilled health professionals;

(ii) national organizations representing hospitals, including teaching hospitals;

(iii) national organizations representing manufacturers of health care products; and

(iv) national organizations representing the business community, health benefit programs, labor, and the elderly.

(C) Subject to such review as the Office deems necessary to assure the efficient administration of the Commission, the Commission may—

(i) employ and fix the compensation of an Executive Director (subject to the approval of the Director of the Office) and such other personnel (not to exceed 25) as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(ii) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(iii) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(iv) make advance, progress, and other payments which relate to the work of the Commission;

(v) provide transportation and subsistence for persons serving without compensation; and

(vi) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

Section 10(a)(1) of the Federal Advisory Committee Act shall not apply to any portion of a Commission meeting if the Commission, by majority vote, determines that such portion of such meeting should be closed.

(D) While serving on the business of the Commission (including travel-time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and his regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority.

(E) In order to identify medically appropriate patterns of health resources use in accordance with paragraph (2), the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice and lengths of hospitalization and on other patient-care data, giving special attention to treatment patterns for conditions which appear to involve excessively costly or inappropriate services not adding to the quality of care provided. In order to assess the safety, efficacy, and cost-effectiveness of new and existing medical and surgical procedures, the Commission shall, in coordination to the extent possible with the Secretary, collect and assess factual information, giving special attention to the needs of updating existing diagnosis-related groups, establishing new diagnosis-related groups, and making recommendations on relative weighting factors for such groups to reflect appropriate differences in resource consumption in delivering safe, efficacious, and cost-effective care. In collecting and assessing information, the Commission shall—

(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this paragraph;

(ii) carry out, award grants or contracts for, original research and experimentation, including clinical research, where existing information is inadequate for the development of useful and valid guidelines by the Commission; and

(iii) adopt procedures allowing any interested party to submit information with respect to medical and surgical procedures and services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

(F) The Commission shall have access to such relevant information and data as may be available from appropriate Federal agencies and shall assure that its activities, especially the conduct of original research and medical studies, are coordinated with the activities of Federal agencies.

(G)(i) The Office shall report annually to the Congress on the functioning and progress of the Commission and on the status of the assessment of medical procedures and services by the Commission.

(ii) The Office shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon its request.

(iii) In order to carry out its duties under this paragraph, the Office is authorized to expend reasonable and necessary funds as mutually agreed upon by the Office and the Commission. The Office shall be reimbursed for such funds by the Commission from the appropriations made with respect to the Commission.

(H) The Commission shall be subject to periodic audit by the General Accounting Office.

(I)(i) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this paragraph.

(ii) Eighty-five percent of such appropriation shall be payable from the Federal Hospital Insurance TrustFund, and 15 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

(J) The Commission shall submit requests for appropriations in the same manner as the Office submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Office.

Source: U.S. House of Representatives, Social Security Amendments of 1983, Report No. 98-47, section 1886(e)(2) through (6), March 24, 1983.

98TH CONGRESS 2d Session | HOUSE OF REPRESENTATIVES | REPORT 98-911

(H.R. 6028)

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATION BILL, 1985

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

The bill includes authority to transfer $2,424,000 from the Medicare trust funds to support the activities of the Prospective Payment Assessment Commission. This is $924,000 more than requested by the President and $924,000 more than appropriated in fiscal year 1984. The amount recommended by the Committee is the same as the amount requested by the Commission in its independent request to the Congress. Together with $708,000 expected to be carried over from 1984, this amount will support an operating budget for the Commission of $3,132,000 in fiscal year 1985.

The Prospective Payment Assessment Commission was established by Public Law 98-121 to advise the Congress and the executive branch on issues related to the new system of Medicare hospital reimbursement enacted by that law. This system provides for paying hospitals under a system of fixed fees based on diagnosis related groups (DRG's). The commission is assigned a broad range of duties under the law including advice on the annual update of the DRG payment levels, advice on restructuring individual DRG's based on new procedures or technologies and general advice on the impact of the new reimbursement system on the cost, quality and effectiveness of the Medicare system in particular and the American health care system in general. The Committee is concerned that many of those organizations and institutions affected by the medicare payment system have come to view the Commission as an all purpose appeal board for resolving each reimbursement issue which arises under the new DRG system. The Committee does not support this view. While the Commission is expected to involve itself in those individual DRG issues which are of very broad impact, it is clear that the rate setting responsibilities under P.L 98-121 are assigned to the Health Care Financing Administration. Concurrently, it is also clear that the Commission has neither the staff nor other resources to become a national center for the evaluation of the safety, efficacy or financial benefits of each new medical procedure or technology which evolves. The Committee believes that the role of the Commission is that of a highly knowledgeable independent panel to advise the executive and legislative branches on the medicare reimbursement system. While this advice includes rate setting and technology assessment, the Committee believes that the primary role of the Commission lies in a broader evaluation of the impact of Public Law 98-121 on the American health care system. The Committee therefore directs that the Commission submit an annual report to the Congress which expresses its view on these issues. The first report should be submitted by October 1, 1985. Included in the amount approved by the Committee is $1 million for research. The Committee expects a substantial portion of these funds to be devoted to this new report.

Amendments to the Deficit Reduction Act

Related to ProPAC

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

97 Stat. 152.
42 USC 1395ww.

SEC. 2313. (a) Section 1886(e)(2) of the Social Security Act is amended by inserting "(without regard to the provisions of title 5, United States Code, governing appointments in the competitive service)" after "appointed by the Director".

(b)(1) Section 1886(e)(6)(C)(i) of such Act is amended to read as follows:

"(i) employ and fix the compensation of an Executive Director (subject to the approval of the Director of the Office) and such other personnel (not to exceed 25) as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);".

(2) Section 1886(e)(6)(C)(iii) of such Act is amended by inserting "(without regard to section 3709 of the Revised Statutes (41 U.S.C. 5))" after "Commission".

(3) Section 1886(e)(6)(C) of such Act is amended by adding at the end the following: "Section 10(a)(1) of the Federal Advisory Committee Act shall not apply to any portion of a Commission meeting if the Commission, by majority vote, determines that such portion of such meeting should be closed.".

5 USC app.

(4) Section 1886(e)(6)(D) of such Act is amended by adding at the end thereof the following sentence: "Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority.".

Ante, p. 1068.

(c) Section 1862 of such Act, as amended by section 2304(c) of this title, is amended by adding at the end the following new subsection

Supra.

"(i) In order to supplement the activities of the Prospective Payment Assessment Commission under section 1886(e) in assessing the safety, efficacy, and cost-effectiveness of new and existing medical procedures, the Secretary may carry out, or award grants or contracts for, original research and experimentation of the type described in clause (ii) of section 1886(e)(6)(E) with respect to such a procedure if the Secretary finds that—

"(1) such procedure is not of sufficient commercial value to justify research and experimentation by a commercial organization;

"(2) research and experimentation with respect to such procedure is not of a type that may appropriately be carried out by an institute, division, or bureau of the National Institutes of Health; and

"(3) such procedure has the potential to be more cost-effective in the treatment of a condition than procedures currently in use with respect to such condition.".

97 Stat. 152.
42 USC 1395ww.

(d) Section 1886(e)(6) of such Act is amended by adding at the end the following new subparagraph:

"(J) The Commission shall submit requests for appropriations in the same manner as the Office submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Office.".

Effective date.
42 USC 1395y note.

(e) The amendments made by this section shall become effective on the date of the enactment of this Act.

Source: Deficit Reduction Act of 1984, Public Law 98-369, July 18, 1984.

Report.
97 Stat. 152.
42 USC 1395ww.

(2) The Prospective Payment Assessment Commission, established under section 1886(e) of the Social Security Act, shall review and report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate regarding the appropriateness of the payment amounts provided under section 1886(d) of such Act for inpatient hospital services associated with implantation or replacement of pacemaker devices and pacemaker leads. Such review shall take into account the time, difficulty, and costs associated with such procedures at the current time in comparison with the time, difficulty, and costs associated with such procedures upon which the payment rates for such procedures under part A of title XVIII of such Act are based.

42 USC 1395c.

Source: Deficit Reduction Act of 1984, Public Law 98-369, July 18, 1984.

Limits for Exempted Hospitals: Conference Report Language

h. Limits for Exempted Hospitals

House bill

No provision.

Senate amendment

The Senate amendment would provide that exempted hospitals and exempted hospital units would be subject to similar rate of increase limitations applicable to their costs (MB − ¼ and MB + ¼) in the same proportion as hospitals under the prospective payment system with the same accounting years. This would result in a rate of increase for exempted hospitals of MB in the first year and MB + ¼ in the second year.

Conference agreement

The conference agreement follows the Senate amendment with a modification. The modification provides that the rate of increase for exempted hospitals and exempted hospital units shall not exceed market basket plus one-quarter percentage point in the first and shall not exceed market basket plus one-quarter of one percentage point in the second year.

The Secretary, taking into account the recommendations of the Prospective Payment Commission, shall continue to have authority to establish a rate of increase, as under current law, but not more than market basket plus one-quarter of one percentage point during the applicable period.

Source: Congressional Record - House, H6724, June 22, 1984

Appendix B

Glossary of Selected Terms[1]

Budget Neutrality: The legislative requirement that Medicare payment for total inpatient operating costs to hospitals under the prospective payment system (PPS) during FY 1984 and 1985 should be neither greater nor less than the estimate of what would have been paid under the law in effect (the Tax Equity and Fiscal Responsibility Act) prior to enactment of prospective payment. (ProPAC Definition)

Case-Mix: The relative frequency of admissions of various types of patients, reflecting different needs for hospital resources. There are many ways of measuring case mix, some based on patients' diagnoses or the severity of their illnesses, some on the utilization of services, and some on the characteristics of the hospital or area in which it is located. (Office of Technology Assessment)

Children's Hospital: A hospital whose inpatients are predominantly under 18 years of age and which has a Medicare provider agreement meeting applicable requirements. (FR 39758)

Classification: The act or process of systematically arranging in groups or categories according to established criteria. Under PPS, patients are classified into disease categories using the ICD-9-CM classification system and then further grouped into diagnosis related groups (DRGs). (ProPAC Definition)

Cost-Based Reimbursement: A method of paying for services based on the costs incurred by a provider to furnish those services. Under Medicare, cost-based reimbursement became associated with a detailed, rigid and prescribed set of rules governing payment. (ProPAC Definition)

Diagnosis Related Groups (DRGs): A system for determining case-mix. Originally developed by researchers at Yale University, the DRG system index classifies patients into groups based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. The DRG classification attempts to categorize patients into clinically coherent and homogeneous groups with respect to resource use. PPS currently uses 468 mutually exclusive DRGs to classify patients and determine case-mix. The first 467 DRGs represent categories wherein the principal procedure is consistent with the principal diagnosis assigned to the patient. DRG 468 represents cases in which the principal procedure is unrelated to the

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[1]The source for each definition is noted following the definition. Those definitions followed by "FR" are from the September 1, 1983 Federal Register, Volume 48, Number 171.

valid principal diagnosis. DRG codes 469 and 470 may be assigned if the Fiscal Intermediary finds certain errors in bills submitted by hospitals. When this occurs, the bills are returned to the hospital for correction. DRGs 469 and 470 are not used as a basis of payment. (ProPAC Definition)

DRG Weight: A number which is intended to reflect the relative resource consumption associated with each DRG. That is, each DRG weight reflects the average cost across all hospitals of treating cases classified in that DRG compared to the average cost for all DRGs. Currently, the DRG weights range from .1842 for DRG 382 (false labor) to 6.8631 for DRG 457 (extensive burns). Because Medicare does not cover heart transplants, DRG 103 has not been assigned a weight. (ProPAC Definition)

Discharge: A hospital inpatient is discharged when: 1) the patient is formally released from the hospital (except when transferred to another hospital under the prospective payment system); 2) the patient dies in the hospital; or 3) the patient is transferred to a hospital or unit that is excluded from the prospective payment system. (FR 39818)

Exempt Hospitals and Units: Childrens', long-term care (average length of stay over 25 days), rehabilitation, and psychiatric hospitals are specifically excluded from the prospective payment system. Rehabilitation or psychiatric "distinct part" subunits of acute care hospitals are exempted if they meet certain criteria as specified by the Secretary. Hospitals located in U.S. Territories (e.g., Puerto Rico), alcohol or drug abuse treatment hospitals or distinct alcohol or drug abuse treatment units of acute hospitals (until October 1, 1985), Federal hospitals, and Christian Science Sanatoria are also exempted. Cancer treatment and research facilities may receive an exemption if they meet criteria established by the Secretary. Exempt hospitals remain under cost-based reimbursement, subject to the TEFRA target rate of increase limits. (FR 39758)

Hospital Market Basket: The set of goods and services purchased by hospitals. (ProPAC Definition)

ICD-9-CM (International Classification of Disease, Ninth Revision, Clinical Modification): A system for classifying diseases and procedures to facilitate collection of uniform and comparable health information. The disease classification is revised every 10 years and the ICD-9 is the 9th version. This system is the basis for grouping patients into DRGs. (Health Care Financing Administration)

Long-Term Care Hospital: Those hospitals which have an average inpatient length of stay more than 25 days. (FR 39758)

Medical Technology: The drugs, devices, and medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided. (Office of Technology Assessment)

Medicare Cost Report (MCR): An annual report required of all institutions participating in the Medicare program which records costs incurred by the institution for providing services to all patients. The costs are defined and reported according to highly specific categories as required by the Medicare program. The 1981 MCRs were used in the development of both the Federal standardized amounts and the DRG weights, which were used to create DRG "prices" under the Medicare Prospective Payment System. (ProPAC Definition)

MEDPAR File (Medicare Provider Analysis and Review File): A HCFA data file which contains billed charge data and clinical characteristics such as principal diagnosis and principal procedures associated with each claim submitted by hospitals. Until October 1, 1983, the MEDPAR file was developed from a 20 percent sample of claims. As of October 1, 1983, the file has been expanded to cover 100 percent of Medicare claims and to include more detailed diagnostic data on all Medicare discharges. The 1981 MEDPAR file was used to create the DRG weights and to derive the case-mix data used in calculating the standardized portion of the prospective payment rates. (ProPAC Definition)

Outliers (atypical cases): Under the Medicare program, cases which have an extremely long length of stay (day outlier) or extraordinarily high costs (cost outlier) when compared to most discharges classified in the same DRG. (FR 39776)

Principal Diagnosis: That condition which after study is determined to be the reason chiefly responsible for occasioning the admission of the patient to the hospital. (FR 39761)

Principal Procedure: The principal procedure is (1) the one most related to the principal diagnosis, or (2) the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes, or was necessary to treat a complication. If only one procedure is performed it is considered the principal procedure. (Health Care Financing Administration)

Prospective Payment (Pricing): A method of paying for health care services in which (1) full amounts or rates of payment are established in advance, and (2) providers are paid these amounts or rates regardless of the costs they actually incur. A distinction is sometimes made between payment and pricing based on whether payment is made in advance for services or whether simply the price is set in advance. (ProPAC Definition)

Psychiatric Hospital: An institution that: (1) primarily engages in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons; (2) satisfies the statutory requirements of a "hospital;" (3) maintains clinical records on all patients such that the degree and intensity of the treatment provided can be readily discerned; (4) meets the special staff requirements for psychiatric hospitals; and (5) is accredited by the Joint Commission on Accreditation of Hospitals. (FR 39755)

Rebasing of PPS Standardized Amounts: The redetermination of the base upon which to project the PPS standardized amounts from new or more recent data, generally cost data. (ProPAC Definition)

Recalibration: The adjustment of all DRG weights to reflect changes in relative resource use associated with all existing DRG categories and/or the creation of new DRG categories. (ProPAC Definition)

Reclassification: The adjustment of certain DRG categories to reflect the creation or elimination of DRG categories or movement of certain diagnosis or procedure codes from one DRG category to another. After reclassification, the resulting categories may need to be reweighted. (ProPAC Definition)

Rehabilitation Hospital: A hospital which has a provider agreement with Medicare, treats an inpatient population of which at least 75 percent require intensive rehabilitative services for one or more of the conditions which are specified in regulation, and which meet other criteria specified by the Secretary in regulation. A rehabilitation hospital must provide active treatment in a number of therapeutic disciplines including physical and occupational therapy. (FR 39819)

Reweighting: The adjustment of only certain DRG weights to reflect changes in relative resource consumption. Reweighting can be done without reclassification. (ProPAC Definition)

Standardized Amounts: The average payment per case for hospitals in a region or nationally, developed using each hospital's average cost per discharge, but excluding costs not paid for under prospective payment, updated for inflation, adjusted for differences in area wage rates, teaching status and case mix of the hospital (standardized) and adjusted for outlier payments, budget neutrality and the addition of new expenses due to changes in statutory requirements. Currently, there are 20 standardized amounts, 18 regional amounts (urban, rural amounts for each of 9 census regions) and 2 national amounts (urban, rural). (ProPAC Definition)

Updating Factor (Rate of Increase Factor): The percentage change applied to the previous year's payment rates which takes into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. The update factor is to reflect changes in the prices of goods and services purchased by hospitals, the hospital "market basket," as well as changes in hospital productivity, technological advances, quality of care and long term cost-effectiveness of services. (ProPAC Definition) More specifically, updating is the adjustment of the base year cost data for inflation. Referred to as an "updating" or "inflation" factor. (FR 39764)

Appendix C.--Prospective Payment Assessment Commission Staff

Name	Starting Date	Education	Experience In:
Meryl Fran Bloomrosen[a]	8/19/84*	B.A. in Linguistics; M.B.A. in Information Systems Technology	medical records, medical information systems, clinical and financial systems; hospital budgeting, staffing, program planning and systems analysis.
Thomas H. Buchberger	2/17/85	B.A. in Political Science; H.H.S.A. in Health Planning and Administration; M.A. in Applied Economics	evaluation of alternative allocations of federal resources in the areas of health insurance for low income groups, tax treatment of health care expenditures, and HMOs; policy analysis and economic research on issues related to hospital capital expenditures
Robin Burman[b]	10/01/84	M.P.A.	analysis and management of public policies and programs; interned in a hospital and in a health planning agency
Dennis J. Cotter	4/16/84	B.S.E.; M.S.E.	biomedical engineering; health policy analysis; evaluation of new medical technologies
Roger Crawford Courtney	12/06/84	B.S. in Pre-Law and Business; J.D.	refining, implementing, and supporting medical applications programs
Kathleen Marie Espy	9/30/84	B.A.; M.P.H.	hospital employment levels; administration of outpatient facilities
Laurie S. Feinberg	8/06/84	B.A.; M.S. in Pharmacology; M.P.H.	Medicare hospital reimbursement; coverage and reimbursement of new technologies; cost containment; national health expenditures
Jolene A. Hall	6/25/84	B.A. in Biology and Medical Technology; M.B.A.; certified medical technologist	healthcare market analysis; research and analysis of new products; strategic planning in the laboratory diagnostics and services market
Andrea Jane Hassol	7/16/84	B.A.; M.S. in Public Health	development of national database for HMOs; other healthcare data needs; cost-effectiveness analysis of medical technology
Carrie Lee Johnson	10/14/84	--	staff support; office systems and procedures
Ann Lezak[b]	8/27/84**	B.A. in Psychology; M.P.A.	mental health care financing; federal health policy development
Candace Lansing Littell	2/04/85	B.S. in Resource Development; M.B.A. in Finance	healthcare management consulting; hospital financial systems; hospital budgeting and rate setting
Carol Ann Lockhart[a]	7/05/84	B.S. in Sociology/Psychology; M.S. in Sociology/Psychology; some doctoral work	health policy management; nursing; public health; labor relations; long-term care
Glenda Gale Love	9/02/84	some college	staff support; office systems and procedures
Suzanne Terese Lusby	6/11/84***	4th year college student	clerk/typist
Judith D. Moore	3/15/84	B.A.; some law school and graduate work in public administration	third-party payment systems; employer attitudes toward healthcare cost containment
Pamela Odom	4/09/84	B.A. in History	staff support; office systems and procedures
Frederick K. Orkin[c]	12/15/84	A.B. in Chemistry; M.B.A. in Health Care Administration; M.D.	anesthesiology; health manpower; quality of care

Name	Starting Date	Education	Experience In:
Lisa Ann Potetz	4/16/84	B.A. in Economics and Political Science; M.A. in Public Policy	hospital costs; health planning; Medicare hospital reimbursement policy
Kurt Franklin Price	10/29/84	B.S.; M.S. in Biostatistics	research studies; statistical analysis and data base construction related to Medicare's Prospective Payment System; refinement of DRGs
Dena S. Puskin	4/15/84	B.A. in Biology and Chemistry; M.A. in Biology and Chemistry; M.S. in Community Medicine; Sc.D.	policy issues related to Medicare and the Federal Employees Health Benefits Program; hospital and physician reimbursement; medical technology; private health insurance; federal tax policy on health insurance
Colleen Virginia Rowland	6/18/84****	2nd year college student	clerk/typist
Edward Lane Siebert	9/30/84	B.A.	health policy research
Elise Donini Smith	12/17/84	B.A. in Economics; some graduate work in Economics; J.D.	Medicare and Medicaid legal issues related to malpractice insurance reimbursement, labor/delivery room policy, treatment of provider interest expenses, drug reimbursement, and various discrete costing issues
Alan Bruce Steinwald	10/01/84	B.A. in Business; M.B.A. in Hospital Administration; doctoral work in Business and Economics	health budget and legislative oversight; economic and policy analysis of health system issues
Michael J. Strauss	7/02/84	A.B. in Economics; M.P.H. expected; M.D.	political history of the artificial heart; effects of bed availability on ICU admissions, discharges, costs and patient outcome; effects of physician specialization and board certification on costs; outcome of care for CDPD patients
Mary Kaye Willian	4/30/84	B.A.; M.S.; M.P.H.; Dr.P.H.	ambulatory care; emergency medical services; manpower planning; healthcare financing; quality of care
Jo Ann M. Yamamoto[a]	12/20/84	B.A.; M.L.A.; post-graduate program in Medical Record Administration	DRG classification and assignment; general issues related to case mix; data quality; medical records
Donald A. Young	2/26/84	M.D.	development of policies, regulations, and implementing instructions for Medicare and Medicaid coverage (benefits), reimbursement and alternative payment mechanisms, eligibility, and entitlement; development and diffusion of health care technologies
Jay Younes	2/26/84	--	administrative assistance; office policy and procedure; staff support

NA indicates not available

* converted to consultant on 12/23/84
** ending date 11/15/84
*** ending date 8/18/84
**** ending date 9/12/84

[a] Consultant
[b] Presidential Management Intern
[c] Robert Wood Johnson Policy Fellow

Source: Prospective Payment Assessment Commission.

Appendix D.--Presentations Before the Prospective Payment Assessment Commission and Its Subcommittees

Organization	Name	Date	Presentation to
Office of Technology Assessment (OTA)	Roger Herdman	12/19/83	Full Commission
Health Care Financing Administration (HCFA)	Carolyn Davis	12/19/83	Full Commission
Pan American Health Organization (Chair, OTA Review Panel)	David Banta	12/19/83	Full Commission
Department of Health and Human Services	Glenna Crooks	12/19/83	Full Commission
Senate Finance Committee	Sheila Burke	12/19/83	Full Commission
House Energy and Commerce Committee, Health Subcommittee	Karen Nelson	12/19/83	Full Commission
Senate Labor and Human Resources Committee	David Nexon	12/19/83	Full Commission
House Ways and Means Committee	Paul Rettig and Diana Jost	12/19/83	Full Commission
Office of Research and Demonstrations, HCFA	Bryan Luce	12/19/83	Full Commission
Office of Technology Assessment	John H. Gibbons and Clyde Behney	2/2/84	Full Commission
Senate Finance Committee	Robert Hoyer	2/2/84	Full Commission
Office of Technology Assessment, Health Program Advisory Committee	Sidney S. Lee	2/2/84	Full Commission
Congressional Budget Office	Paul B. Ginsburg	2/2/84	Full Commission
Health Care Financing Administration	Patrice H. Feinstein	2/2/84	Full Commission
Health Care Financing Administration	Regina McPhillips and Vince Acquisto	2/3/84	Full Commission
United Hospital Fund of the City of New York	Bruce Vladeck	2/3/84	Full Commission
Washington Business Group on Health	Willis B. Goldbeck	2/3/84	Full Commission
American Medical Association	John C. Beljian	2/3/84	Full Commission
Blue Cross and Blue Shield	Bernard R. Tresnowski and Larry Morris, Sr.	2/3/84	Full Commission
Health Industry Manufacturers Association	Frank E. Samuels, Jr. and Wayne Roe	2/3/84	Full Commission
American Hospital Association	Edmund B. Rice	2/3/84	Full Commission
American Society of Internal Medicine	Eugene Ogrod	2/3/84	Full Commission
Health Insurance Association of America	Karen Williams	2/3/84	Full Commission
American College of Physicians	Francis Sweeney and John Ball	2/3/84	Full Commission

Appendix E.--Attendance of Commissioners

Commission Members	Meeting Dates 12/19-20/83	2/2-3/84	5/30/84	9/12/84	11/7/84	1/16/85	2/13/85	3/6/85	Percent Attendance
Stuart H. Altman, Chair	X	X	X	X	X	X	X	X	100%
Karl D. Bays	X	X	X	X	X	X			75
Harold A. Cohen	X	X	X	X	X	X	X	X	100
John W. Colloton	X	X	X	X	X	X	X	X	100
Yvette F. Francis	X	X	X		X	X	X	X	88
Sister Sheila Lyne	X	X	X		X	X		X	75
Barbara J. McNeil	X	X	X	X	X	X	X	X	100
Richard J. Mellman	X	X	X	X	X	X	X	X	100
James J. Mongan	X	X	X	X	X	X	X	X	100
John Clark Nelson	X	X	X	X	X	X	X	X	100
Ernest W. Saward	X	X	X	X	X	X	X	X	100
Steven A. Schroeder		X	X	X	X	X	X	X	88
Bert Seidman	X	X	X	X	X	X	X	X	100
M. Keith Weikel	X	X	X	X	X	X	X	X	100
Irwin Wolkstein	X	X	X	X	X	X	X	X	100

Subcommittee on Data Development and Research	11/7/84	1/16/85	2/13/85	3/6/85	Percent Attendance
Steven A. Schroeder, Chair	X	X	X	X	100%
Harold A. Cohen	X	X	X	X	100
Yvette F. Francis	X	X	X	X	100
Barbara J. McNeil	X	X	X	X	100
Richard J. Mellman	X	X	X	X	100
Irwin Wolkstein	X	X	X	X	100
[Stuart H. Altman]*	X		X	X	NA

Subcommittee on Diagnostic and Therapeutic Practices	7/4-5/84	9/10-11/84	10/9-10/84	12/12-13/84	2/12/85	3/5/85	Percent Attendance
Barbara J. McNeil, Chair	X	X	X	X	X	X	100%
Karl D. Bays	X	X	X	X	X		83
John W. Colloton	X	X	X		X	X	83
John Clark Nelson	X	X	X	X	X		83
Ernest W. Saward	X	X	X		X	X	83
Steven A. Schroeder	X		X	X		X	67
Irwin Wolkstein	X	X	X	X	X	X	100
[Stuart H. Altman]*	X	X		X	X		NA

Subcommittee on Hospital Productivity and Cost-Effectiveness	7/9-10/84	8/9-10/84	9/11/84	10/15-16/84	12/10-11/84	1/15/85	2/12/85	3/5/85	Percent Attendance
Harold A. Cohen, Chair	X	X	X	X	X	X	X	X	100%
Yvette F. Francis	X	X		X	X	X	X	X	88
Sister Sheila Lyne	X	X	X	X	X	X	X	X	100
Richard J. Mellman	X	X	X		X	X	X	X	88
James J. Mongan	X		X	X	X	X		X	75
Bert Seidman	X	X	X	X	X	X	X	X	100
M. Keith Weikel	X	X	X	X		X		X	75
[Stuart H. Altman]*		X	X	X		X	X	X	NA

NA indicates not applicable

*As Commission Chair, Stuart H. Altman is not a member of any of the subcommittees but has attended many of their meetings.

Organization	Name	Date	Presentation to
American Federation of State, County and Municipal Employees, AFL-CIO	Robert E. McGarrah	5/30/84	Full Commission
National Union of Hospital and Health Care Employees	Robert L. Brand	5/30/84	Full Commission
Service Employees International Union	Cathy Schoen	5/30/84	Full Commission
Health Care Financing Administration	Patrice H. Feinstein	9/12/84	Full Commission
National Center for Health Services Research	John Marshall	9/12/84	Full Commission
Health Care Financing Administration	Patrice H. Feinstein and James L. Scott	11/7/84	Full Commission
Pan American Health Organization	David Banta	11/7/84	Full Commission
Office of Technology Assessment	Roger Herdman	11/7/84	Full Commission
Rand Corporation	K. Lohr	12/12/84	Subcommittee on Diagnostic and Therapeutic Practices
Abt Associates	Gary Gaumer	12/12/84	Subcommittee on Diagnostic and Therapeutic Practices
Health Care Financing Administration	Michael Hupfer	8/10/84	Subcommittee on Hospital Productivity and Cost-Effectiveness
New York State Department of Health	Robert Barnett	8/10/84	Subcommittee on Hospital Productivity and Cost-Effectiveness
Private Consultant	Jack Cooke	8/10/84	Subcommittee on Hospital Productivity and Cost-Effectiveness
Maryland Hospital Association	Nick Desein	8/10/84	Subcommittee on Hospital Productivity and Cost-Effectiveness
Health Care Financing Administration	Mark Freeland	9/11/84	Subcommittee on Hospital Productivity and Cost-Effectiveness
American Heart Association	Joseph Martin	9/11/84	Subcommittee on Hospital Productivity and Cost-Effectiveness
Data Resources, Inc.	Mariana McNeill	9/11/84	Subcommittee on Hospital Productivity and Cost-Effectiveness
Congressional Research Service	Julian Pettengill	10/15/84	Subcommittee on Hospital Productivity and Cost-Effectiveness
Health Care Financing Administration	Allen Dobson	10/15/84	Subcommittee on Hospital Productivity and Cost-Effectiveness
National Association of Public Hospitals	Dennis Andrulis	10/15/84	Subcommittee on Hospital Productivity and Cost-Effectiveness
University of Pittsburyh	Judith Lave	10/16/84	Subcommittee on Hospital Productivity and Cost-Effectiveness
District of Columbia Hospital Association	John L. Ashby, Jr.	12/11/84	Subcommittee on Hospital Productivity and Cost-Effectiveness
American Heart Association	Joseph Martin and David Dolkart	12/11/84	Subcommittee on Hospital Productivity and Cost-Effectiveness
The Brookings Institution	Louise Russell	2/12/85	Subcommittee on Hospital Productivity and Cost-Effectiveness

Appendix F

Procedure for Submission of Information to the Commission

Federal Register / Vol. 50, No. 8 / Friday, January 11, 1985 / Notices 1657

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Procedure for Submission of Information With Respect to Medical and Surgical Procedures and Services

AGENCY: Prospective Payment Assessment Commission.

ACTION: Notice

SUMMARY: The Prospective Payment Assessment Commission is required by Congress to adopt procedures allowing interested parties to submit information to the Commission with respect to medical and surgical procedures and services. To implement this mandate the Commission has developed guidelines that can be used by those parties interested in submitting information. The guidelines and material describing the process established by the Commission for reviewing and analyzing submitted information are available from the Commission. Information submitted shall be reviewed by the Commission and considered in its recommendations and reports to the Secretary of the Department of Health and Human Services and Congress.

To Acquire Materials Contact: Pamela Odom, Administrative Assistant, Prospective Payment Assessment Commission, Suite 301B, 300 7th Street SW., Washington, D.C. 20024.

SUPPLEMENTARY INFORMATION: In Pub. L. 98-21, Congress amended the Social Security Act (the "Act") to provide for a prospective payment system for Medicare payment of inpatient hospital services. Under this system, Medicare payment is made at a predetermined specific rate for each discharge. Hospital discharges are classified into diagnosis related groups (DRGs), and, at the present time, this list contains 470 specific groups. Congress, in Pub. L. 98-21, also provided for the establishment of the Prospective Payment Assessment Commission (the "Commission"). The Commission is directed in section 1886(d)(4)(D) of the Act to make recommendations to the Secretary with respect to adjustments to the DRG classification and weighting factors and report to Congress with respect to its evaluation of any adjustments made by the Secretary.

The Commission also makes recommendations to the Secretary, as provided in section 1886(e)(2) and 3, on the appropriate percentage change factor to be used in updating Medicare payments.

In connection with these responsibilities, the Commission is required, pursuant to section 1886(e)(6)(E) of the Act, to collect and to assess information on medical and surgical procedures and services in order to identify appropriate patterns of health resource use and to assess the safety, efficacy and cost effectiveness of new and existing medical and surgical procedures. One of the methods of collection and assessment prescribed by Congress is for the Commission to—

> Adopt procedures allowing any interested party to submit information with respect to medical and surgical procedures and services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress. Section 1886(e)(6)(E)(iii).

To implement section 1886(e)(6)(E)(iii) of the Act, quoted above, the Commission has prepared guidelines for submitting information for consideration and material explaining the Commission's mandate and process of analyzing submitted information. Any interested party who wishes to submit information to the Commission on new and existing medical and surgical procedures and services can request the guidelines and accompanying material.

At present, the guidelines focus on issues regarding medical and surgical procedures and services that may potentially require adjustments to the DRG classification or weights. The submissions of interested parties will be reviewed by the Commission staff and referred to the Subcommittee on Diagnostic and Therapeutic Practices. This subcommittee was established by the Commission to analyze issues related to new and existing procedures, services and technologies, particularly as these issues relate to changes that the Commission will recommend in the DRG classification and weight system used by the Medicare prospective payments system.

Use of the guidelines is not required nor are they intended to prescribe or limit the type of information submitted. However, they do identify the specific types of information that the Commission needs in order to analyze the procedure or service in question. Thus, their use will facilitate review. The Commission welcomes comments on the guidelines.

Donald A. Young,

Executive Director.

[FR Doc. 85-844 Filed 1-10-85; 8:45 am]

BILLING CODE 8820-SW-M

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

GUIDELINES FOR THE SUBMISSION OF INFORMATION WITH RESPECT TO MEDICAL AND SURGICAL PROCEDURES AND SERVICES

I. General Information/Background

Where appropriate, include the following information.

- Description of the technology or the medical or surgical procedure or services
- Identification of Food and Drug Administration approval status, if appropriate
- Summary of findings from clinical research including literature references
- Discussion of alternative diagnostic or therapeutic approaches to achieve the same health outcome
- Estimation of the current or potential application of the procedure or service and size of the population affected, with an emphasis on the Medicare population

II. Quality of Care Considerations

Quality of care issues are very important to the Commission. Where appropriate, the following can be discussed.

- Safety and efficacy of the technology, procedure or service
- Short-term and long-term risks and benefits to patients
- Comparison of the procedure or service being discussed with alternative approaches
- The impact of the procedure or service on an entire episode of illness including outpatient as well as inpatient care, with the emphasis on quality of care considerations
- Patient access to care
- Patient satisfaction with care

III. Economic Considerations

To the extent possible, the following factors can be discussed.

- Unit cost of the technology, procedure or service as well as estimated aggregate costs for all patients (Medicare and/or total) for whom it might be used
- Costs of care for a hospital admission as well as costs of care for an entire episode of illness
- Capital costs associated with adopting and using the technology, procedure or service
- Operating costs associated with adopting and using the technology, procedure or service
- Applicable cost-effectiveness studies

IV. DRG Classification and Weight Analysis

Medicare payments are based upon a patient classification system -- diagnosis related groups (DRGs). The Commission is required to evaluate the appropriateness of DRG classification and weights and to recommend needed adjustments to this system. Where appropriate, the following factors could be addressed.

- Diagnostic or procedure coding within the ICD-9-CM system
- DRG grouping (e.g., Is there a more appropriate DRG into which costs involving this procedure should be grouped? Is the grouping of these cases or services clinically meaningful?)
- Appropriateness of current DRG weights or payment amounts
- Variation in use of the technology, procedure or service among types of hospitals (e.g., urban or rural location)

V. Other Issues

Other considerations may include the potential effects of the technology, procedure or service on the Medicare population and society. Such consideration may concern ethical and legal issues.

IV. Data Availability

To the extent possible, please provide data or information on available data sources that may be used in analyzing the issue.

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

PROCESS FOR IDENTIFICATION AND ANALYSIS OF ISSUES RELATED TO DRG CLASSIFICATION AND WEIGHT

I. Responsibilities of the Prospective Payment Assessment Commission (ProPAC)

Congress has charged the Secretary of the Department of Health and Human Services with adjusting the classification and weights of the diagnosis related group (DRG) patient classification system, which serves as the basis for Medicare's payments for inpatient hospital discharges. Adjustments are to be made in fiscal year 1986 and at least every four years thereafter to reflect changes in technology, treatment patterns and other factors that may alter the use of hospital resources.

The Commission's responsibilities include:

- Consulting with and making recommendations to the Secretary regarding the need for adjustments to the DRG system based on its evaluation of scientific evidence regarding new practices, including the use of new technologies and treatment modalities.

- Collecting and assessing factual information to evaluate the safety, efficacy and cost-effectiveness of new and existing medical and surgical procedures. Special attention is to be given to updating existing DRGs, establishing new DRGs and making recommendations on relative weighting factors for such groups to reflect appropriate differences in resource consumption in delivering safe, efficacious and cost-effective care.

- Adopting procedures allowing interested parties to submit information regarding medical and surgical procedures and services (including new practices, such as the use of new technologies and treatment modalities). The Commission is to consider this information in making reports and recommendations to the Secretary and Congress.

II. Interim Process

The Commission has established a three-stage interim process for identifying and analyzing issues that may potentially require adjustments in the DRG classifications and/or weights.

A. Identification of Issues

Issues will come to the Commission's attention from two sources: (1) ProPAC's internal assessment and/or (2) interested parties such as Congress, professional societies, hospitals or manufacturers. Issues are likely to be of three general types: those related to individual technologies; those associated with health care practice patterns; and those involving a problem with DRG classification or weight.

B. Screening Analysis

This analysis summarizes information regarding safety and efficacy of the technology (if appropriate), the populations affected, quality and costs of service, availability of data, and issues related to the DRG classification and weight. ProPAC's staff will develop the Screening Analysis based on internal review including information submitted by interested parties. The "Guidelines for the Submission of Information with Respect to Medical and Surgical Procedures and Services" outlines the types of information that may be useful for thorough consideration of the issue.

ProPAC's Subcommittee on Diagnostic and Therapeutic Practices will review the Screening Analysis and recommend to the Commission whether an indepth analysis should be undertaken for the purposes of developing recommendations for the reports to the Secretary and Congress.

C. Indepth Analysis

This analysis provides detailed review of the issue including options for Commission action in developing recommendations to the Secretary. As with the Screening Analysis, ProPAC's Subcommittee on Diagnostic and Therapeutic Practices will review the information and make a recommendation for action to the full Commission.